

VIRAL SEROLOGY TEST REQUEST

1. Please provide the patient information requested. 2. Type or print with pressure. 3. Send all copies of this form with specimen to STATE PUBLIC HEALTH LABORATORY.		DATE SPECIMEN COLLECTED ACUTE	DATE RECEIVED ACUTE	STATE LAB SERIAL NO.	
		CONV	CONV		
PATIENT NAME (LAST, FIRST)		ONSET	DATE CONV. REQ'D		
ADDRESS (CITY, STATE, ZIP CODE)		SPECIMEN TYPE <input type="checkbox"/> Serum <input type="checkbox"/> CSF	FOR STATE HEALTH LAB USE ONLY		
BIRTHDATE		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	DATE REPORTED		
RACE <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> AI/AN <input type="checkbox"/> O/U		RUBEOLO/RUBELLA VACCINATION HISTORY	LABORATORY REPORT		
MEDICAID NUMBER		TEST REQUESTED: Please indicate below, see back of form for test description.	RUBEOLO EIA (IgM): <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal		
The following information MUST BE PROVIDED before testing can be performed:		<input type="checkbox"/> Measles (Rubeola) IgM EIA <input type="checkbox"/> Rubella IgM EIA <input type="checkbox"/> Arbovirus <input type="checkbox"/> Rickettsial Panel <input type="checkbox"/> Other: CDC Referrals	RUBELLA EIA (IgM): <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal		
PERSON'S NAME AUTHORIZED TO RECEIVE PHONE RESULTS					
FACILITY/LAB PHONE NO.					
FACILITY/LABORATORY NAME					
FACILITY/LABORATORY STREET/MAILING ADDRESS					
FACILITY/LABORATORY CITY, STATE & ZIP CODE			MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES STATE PUBLIC HEALTH LABORATORY 307 W McCARTY, PO BOX 570 JEFFERSON CITY MO 65101		
			EOAA EMPLOYER Services Provided on a non-Discriminatory Basis		